

Massachusetts Child Fatality Review Program

2015 Status Report

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Executive Summary

A child's death is a sentinel event that should urge communities to identify other children at risk for illness or injury.¹ The purpose of Child Fatality Review (CFR) is to conduct a comprehensive, multi-disciplinary review of child deaths, to better understand how and why children die, and to use the findings to take action that can prevent other deaths and improve the health and safety of children.² In Massachusetts, Local Child Fatality Review Teams examine the circumstances of child deaths under their jurisdiction to determine if the death was preventable and to formulate recommendations outlining education, policy, and prevention action steps to take to prevent similar deaths in the future. These local recommendations inform the statewide prevention efforts of the State CFR Team.

During 2015, Local CFR Teams reviewed 117 child deaths and made more than 50 recommendations to the State CFR Team to prevent future deaths. More information on the types of deaths reviewed can be found on page 2 of this report. A complete list of all recommendations made to the State CFR Team during 2015 can be found on pages 3-9.

Activities of the State CFR Team in 2015 included releasing a document on best practices for school districts to school swimming pools (<http://www.doe.mass.edu/cnp/resources/SwimmingPools.pdf>), revising the Sudden Unexpected Infant Death (SUID) investigation form used by state and local police for investigation of unexplained deaths among children under 3 years of age to better match national data collection standards, and developing an agenda for future work based on a needs assessment.

At both the state and local level, Child Fatality Review continues to be an unfunded mandate. Local Team coordinators struggle with balancing existing work responsibilities with coordinating Local Team meetings, developing Local Team guidelines, gathering records for the review, and submitting data to the State Team and the National Child Death Review case reporting system. Delays in both death certificate and surveillance data also affect Local and State Teams' abilities to focus prevention efforts and measure progress. In 2015, a CFR improvement working group was formed to brainstorm challenges and opportunities of the Child Fatality Review process in Massachusetts. As a result of this working group, a retreat for all State Team members was held in 2016 and a set of action steps was created. These include: developing a process for immediate feedback on recommendations made by the Local Teams to the State Team, drafting a document that includes a list of barriers to the CFR process in Massachusetts and what an effective structure and budget would look like, and piloting more targeted child fatality reviews.

Looking forward, the State CFR Team plans to continue implementation in 2016 and 2017 of the action steps that resulted from the CFR improvement working group. Other future activities of the State CFR Team include continuing to work with the Office of the Chief Medical Examiner and the Department of Public Health to better understand the circumstances of SUID cases in Massachusetts and to work together to find ways and means of preventing child deaths in Massachusetts, including conducting a needs assessment among the local child fatality review teams state-wide.

¹ The National Center for the Review & Prevention of Child Deaths, Michigan Public Health Institute. Retrieved on July 16, 2015 from: <https://www.childdeathreview.org/cdr-process/cdr-principles/>

² Ibid.

Massachusetts State Child Fatality Review Team Members

Chief Medical Examiner (**Co-Chair**)

Commissioner of Dept. of Public Health or designee (**Co-Chair**)

Mandated State Child Fatality Review Team

- Attorney General, or designee
- Commissioner of Dept. of Elementary and Secondary Education, or designee
- Commissioner of Dept. of Mental Health, or designee
- Commissioner of Dept. of Developmental Services, or designee
- Commissioner of Dept. of Children and Families, or designee
- Commissioner of Dept. of Youth Services, or designee
- Representative of Mass. District Attorney's Association, or designee
- Colonel of Mass. State Police, or designee
- Director of Mass. Center for Sudden Infant Death Syndrome (SIDS), or designee
- Representative of the Mass. Chapter of the American Academy of Pediatrics with experience in child abuse and neglect
- Representative of the Mass. Hospital Association
- Chief Justice of the juvenile division of the trial court
- President of Mass. Chiefs of Police Association
- Office of the Child Advocate
- Other individuals with information relevant to cases under review

Mandated Local Child Fatality Review Team Members

- Chief Justice of the juvenile division of the trial court, or designee
- Commissioner of Dept. of Public Health, or designee
- Commissioner of Dept. of Children and Families, or designee
- District Attorney of county (**chair**)
- Director of Mass. Center for Sudden Infant Death Syndrome (SIDS), or designee
- Pediatrician with experience in child abuse and neglect
- Local police officer from the community where the fatality occurred
- State law enforcement officer
- Other individuals with information relevant to cases under review

Massachusetts Local Child Fatality Review Team Coordinators
As of November, 2016

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Local Team Meetings and Types of Cases Reviewed, 2015

Information in the log below is based on summary forms submitted to the MA Department of Public Health (DPH) following Local Team meetings. These forms are used to compile basic statistics on the number of meetings Local CFR Teams held, the number and manner of death of cases reviewed, and the number of recommendations submitted to the State CFR Team. The information presented in this report is based only on forms submitted to DPH, and therefore will not reflect meetings held and cases reviewed where a summary form was not completed and/or submitted.

Team	Dates of Meetings where cases completed	Total Number of Case Review Forms Submitted*	Natural	Accident	Suicide	Homicide	Unde-termined	Other or Missing Manner	Near Fatality	Total Number of Cases with Recommendations
Berkshire										
Bristol	3/23/2015	5			2		3			5
Cape and Islands	9/9/2015	18	11	2			2	3		2
Essex	1/21/2015 4/15/2015	3	2				1			1
Hampden	4/1/2015 5/6/2015 6/3/2015 9/2/2015 11/4/2015 12/2/2015	31	18	3	1	6	3			13
Middlesex	3/20/2015 6/12/2015 9/25/2015	10	2		3		5			10
Norfolk	3/18/2015 6/17/2015 9/16/2015 12/9/2015	29	24	2	2			1		3
Northwest	4/14/2015 7/14/2015	6	1	2	1		2			5
Plymouth	4/6/2015 8/6/2015	6	1	4	1					6
Suffolk										
Worcester	9/23/2015 12/7/2015	9	3	1	5					3
Total		117	62	14	15	6	16	4	0	48

Local Team Recommendations	
Team	Recommendations: Homicide
Hampden	<p>Problem - Social issues. During infancy and early childhood, parents should have frequent home visits, emotional support, and referrals for services. The State Team should consider reviewing current evidence-based home-visiting practices and encourage their use statewide.</p>
	<p>Serious at-risk and antisocial behavior is the consequence of lifelong social dysfunction that can be identified as early as preschool. Evidence-based programs for dealing with these problems early exist, but correction becomes increasingly difficult as children age. The State Team should consider a concerted review at the state level of how we are dealing with at-risk children through the lifespan and beginning in preschool. There is a need for a multi-disciplinary approach to address the issue of youth violence, which should include services being offered to children and families and involvement from local school departments. Local faith communities, cultural groups, early education and care organizations, medical care providers, and social service agencies can be a safety net for families in distressed communities and should be included as part of the effort. It is further recommended to monitor the development of executive functioning and intervening early with children.</p>
	<p>The State Team should consider the need to expand the scope of intervention-based programs, build the capacity of current incentive-based programs, and consider behavioral health programs that address stigma and utilize non-conventional methods to address this problem. Current practices aimed at reducing desensitization to youth violence and enhancing positive youth development should be promoted statewide. Unfortunately, there is limited funding for children with behavioral/emotional regulation programs-agencies do not have sufficient resources to reach and educate all youth with behavioral/emotional regulation problems.</p>
	<p>DPH and the Children's Trust Fund have implemented the All Babies Cry Program, which is an evidence-based media intervention designed to prevent child abuse during the first year of life by encouraging healthy parenting behaviors. A recent study of this program found that it is significantly effective with improving behaviors of first-time/new parents.</p> <p>Problem - Management of infant crying. It is recommended for the State Team to review the current state of the All Babies Cry Program; it is presently geared toward first-time/new parents. The scope of the program should also include such training for other types of caregivers, i.e. babysitters. On DPH's website there are fact sheets available in several languages. However, the media educational materials are not universally accessible. Furthermore, these programs should be specific and financially practicable for hospitals as there is the need for more financial resources to implement these programs. To prevent future untimely deaths, there is the need for a funded, well-constructed, and universal training program.</p>

Team	Recommendations: Injury
Cape and Islands	1) Additional funding for education on bicycle safety and helmet use geared toward adolescents 2) Provide bike rental companies information on bike helmet use including having helmet and bike rented together (with possible incentive) 3) Add signage at strategic location for bike riders (i.e. bike trails) 4) Public awareness campaign to bike stores, bike rental companies, rails to trails, ferries to islands
Hampden	Problem - Junior operators are allowed, but not required, to obtain both Class D and Class M permits at the same time. In order to receive a Class M license, a junior operator must meet all of the requirements for a Class D license but the same is not a prerequisite when obtaining a learning permit. To prevent future untimely deaths, it is recommended for the State Team to review our Junior Operator Law (JOL); it presently allows children under the age of 18 to operate motorcycles on the road unsupervised prior to mastering the necessary skills for operating both automobiles and motorcycles. The risk of injury, particularly death, is significantly higher within a motorcycle versus an automobile.
	1) The State team should consider a concerted effort to encourage the use of current evidence-based psychotherapeutic practices by Children's Behavioral Health Initiative providers. The State team should also consider a concerted effort to allow psychotherapeutic practices in which the therapist primarily works with the parent/guardian, when the identified patient has disruptive or dysregulated behavior problems. 2) The State team should consider the standard protocols for state truck inspections, should require truck drivers to check/inspect trucks pre-trip, including brakes, in addition to annual inspections. 3) The State team should consider reviewing current practices of bike safety and education for children and families.
Plymouth	We recommend that parents be reminded about the importance of first aid and CPR, including the Heimlich maneuver. We would like for community education and opportunities for training on first aid to be more readily available.
	We recommend that physicians and pharmacies instruct patients and their families to whom they prescribe MAOI drugs about the hazards of mixing those drugs with others. We recommend that verbal and written instructions accompanying the prescription for MAOIs mandate that the drugs be kept in a locked, secure place. We would recommend that DPH and/or the proper governing authority make these needs clear to physicians and pharmacists.
	For this very tragic accident, we recommend the addition of constructive places for recreation for teens and tweens to play in urban areas, like skate parks and fields.
	We recommend the facilitation of more community swim lessons and water safety education for underserved populations, especially those with special needs. We urge the State Team to continue its discussion about and action around making natural bodies of water safer.

Team	Recommendations: Natural
Essex	<p>1) Hospitals should make referrals to home visiting programs for high medical risk infants/children.</p> <p>2) DPH and/or Children's Trust should fund home visiting for high medical risk infants for first year of life (8-10 visit minimum).</p>
	<p>1) Polysubstance abusing mothers - What is the number of pre-mature/early infant death cases on an annual basis in MA where mom is a suspected user of prescribed or illegal narcotics (high risk situations)?</p> <p>2) Concerns of sub Oxone use with other prescribed or illegal narcotics - Need to educate both physicians and their patients as to the lethal mix that can occur if there is sub Oxone use and patient does not reveal such use to a prescribing physician. Education campaign warning of the dangers of co-mingling additional narcotics with suboxone use.</p>
Hampden	<p>The State Team should consider the need to increase the capacity of the Department of Children and Families' (DCF) involvement with Parent Aides. More parental and familial support is needed in the home pre and postpartum. Currently, Parent Aides are not employed by DCF; they are trained service providers contracted from outside agencies. Multiple problems exist with this arrangement:</p> <p>1) DCF has a limited number of contracted "spots"</p> <p>2) There is a waitlist with cases assigned to families by priority</p> <p>3) Low pay and high turnover of staff hinders the effectiveness of this program</p> <p>4) Although Parent Aides are mandated reporters, their alliance with the family could contribute to delays in reporting to DCF. Increasing these resources and placing them closer to, or within the agency, will improve prevention services and speed identification when prevention services are inadequate or breaking down.</p>
	<p>For the State Team to consider the need for an improved and sustained effort to support hospice and families</p>
	<p>That the State Team consider the need for access/ability to obtain the prenatal records reviewed by an obstetrician</p>
Middlesex	<p>1) Have DPH calculate how many allergy deaths there have been for children in the Commonwealth</p> <p>2) Reach out to community organizations dealing with allergies to help in outreach and messaging surrounding awareness and best practices for parents of children with allergies.</p> <p>3) Recommend medical team working with high-risk patients conduct home inspections to ensure environment is appropriate for the child and won't exasperate their medical condition</p> <p>4) Recommend medical team working with families who have children with allergies talk to the family about the importance of taking medications on time, recognizing the signs of an attack, understanding how quickly an attack can turn fatal, and having... ..parents closely monitor and supervise the use of medication.</p> <p>5) Develop application to monitor asthma for children at risk of hospitalization. Doctors would be able to check levels, refill prescriptions & have open line of communication with parent/child</p>
Norfolk	<p>The Norfolk team is seeking a speaker to come and discuss the correlation between drug/opiate use and prematurity and baby deaths.</p>

Team	Recommendations: Sudden Unexpected Infant Death (SUID)
Bristol	<ul style="list-style-type: none"> 1) Increase awareness and warnings to parents/guardians regarding any sleep aids and their effect on responsiveness to needs of infants/children. 2) Premature babies: increased risk - increase awareness with co-sleeping even at 6 months of age. 3) Increase awareness of risks consistent with developmental ages: infants easily suffocated; mobile child suffocates in sheets/bedding or wedging. Emphasize cultural sensitivity. 4) Student awareness - early intervention and babysitting and first aid.
	<ul style="list-style-type: none"> 1.) Instruct culturally on sleep positions. 2) Sudden unexpected infant death case investigation form was included which helped with our understanding of the case.
	<ul style="list-style-type: none"> 1) Continue education on safe sleep situations. 2) Involve child products - marketing - TV. 3) Reinforce no co-sleeping at doctor's appointments.
Cape and Islands	Continued support for safe sleep practices and universal education of safe sleep practices which would include sleeping while napping.
Essex	Prior recommendations on co-sleeping issues have been made - however, need to discuss getting information out to rural and suburban areas. Unlicensed daycare - Clarifying unlicensed daycares (use of family/friend vs. private). How many death cases come to the state team while in unlicensed daycares? Need to have Early Education and Care come to a meeting. Possibly have someone from DPH speak about visits.
Hampden	<ul style="list-style-type: none"> 1) Data on socio-economic status data should be included in future SUID/SIDS studies. 2) It is recommended for hospitals and state agencies providing services to parents, families and caretakers to continue with their efforts in providing education regarding the risks of co-sleeping in relation to SUID. 3) The State Team should consider the need to expand current practices of public education on the risks of smoking to include the effects of third hand smoke on infants and children. 4) The State Team should take measures to assure that standardized assessment for infant death investigations is adopted and implemented statewide to improve the quality of the data being obtained through interviews. It is recommended that initial and periodic re-training is offered to all law enforcement on SUID and SIDS.

Team	Recommendations: Sudden Unexpected Infant Death (SUID)
Middlesex	<p>1) Hospitals need to include full messaging about safe sleep practices (when to stop skin to skin contact and put baby in crib). Do more monitoring and feedback for moms about how well they're doing with safe sleep practices while in the hospital.</p> <p>2) Approach news programs about doing special features on safe sleep for 6/11pm broadcasts to reach grandparents and other audiences.</p>
	<p>Increase appropriate and consistent exposure to safe sleep messaging:</p> <p>1) Ask DPH to use social media to out safe sleep messages and find a famous champion to do this-someone with a lot of followers.</p> <p>2) Require safe sleep info to be part of babysitting class curricula.</p> <p>3) Reach out to film/TV production that occurs in MA about including modeling safe sleep when a scene is relevant.</p>
	<p>Improve timeliness of OCME findings (36 2014 pending cases and some still pending from 2011 and 2012 at time of meeting). Middlesex recommends setting up a qualified commission to conduct a needs assessment with the OCME to help them advocate for what they need - determine what the workload requirements are, what resources are needed to improve function of office and turnaround time for cases. As part of this process, talk to families, law enforcement, and others regarding impact of delays in case processing including child fatality review teams.</p>
	<p>1) Expand infant safe sleep awareness efforts through social media (Twitter campaign, Instagram, etc.)</p> <p>2) Broach balance between attachment parenting and recommended infant safe sleep practices</p> <p>3) Expand educational materials and provide training to Doulas and Midwives.</p> <p>4) Have birth hospitals emphasize the difference between "bed sharing" and "co-sleeping"</p>
Norfolk	<p>The Norfolk Team recommends that the safe sleep initiatives include references to the dangers of co-sleeping with dogs and the SUID investigation form include a box for data collection regarding dogs being present in home or in co-sleeping environment.</p>
Northwest	<p>Need to identify at risk families, daily visits, educate on co-sleeping and parents should know CPR.</p>
	<p>Greater education to midwives regarding mandated reporting and reaching out to community to provide additional training on co-sleeping, etc.</p> <p>Also change in law when adult under the influence be held criminally responsible with mental health or medical intervention.</p>
	<p>Additional information on safe sleep to parents. Parents to share that information with caregivers.</p>
Plymouth	<p>For every placement by the Department of Children and Families of an infant (including kinship placements), DCF workers should view the sleep placement area, give a pamphlet and have a conversation about safe sleep. We encourage DCF to incorporate this policy/practice for workers placing infants, even in kinship or current foster placements.</p>

Team	Recommendations: Suicide
Bristol	<ol style="list-style-type: none"> 1) Increase awareness with children and families of benefits of therapy as an acceptable intervention for all ages. 2) Review statewide data on suicides - by age; culture; "clustering". 3) Communities to consider a plan after teen suicide occurs to prevent clustering. 4) Plan when youth/teen suicides occur in the summer to provide a school based intervention.
	<ol style="list-style-type: none"> 1) Provide additional screening programs for high risk students that address some of their needs. 2) Have PCP/school refer a child for increased services once identified as at risk. Mandate summer plan. 3) Prioritize high risk students for therapy. 4) Recommend protocols to increase communication between probate court, school and DCF. 5) Implement QPR with follow-up and data collection. 6) Student awareness-health class. 7) Increase capacity of resources.
Hampden	<p>That the Department of Education consider the need to develop a standardized, evidence-based, systematic suicide prevention and awareness educational program for students within the public school system. Every school district may have its own program. Also it should be taken into consideration that there may be some resistance with the religious communities.</p>
Middlesex	<p>The State Child Fatality Review Team should seek change in Child Fatality Review legislation to allow communication between local CFRTs and people who responded to cases regarding lessons learned to allow some sort of feedback mechanism - the backlog in release of statewide report was cited here. Also, report was viewed as not sufficient for local needs. Look to Florida's Intimate Partner Violence homicide review as a model.</p>
	<ol style="list-style-type: none"> 1) Enhance the availability of the texting service offered by Samaritans. 2) DESE should increase the availability of training for recognizing and reporting what you observe in peers for students (e.g., the SOS training). 3) Enhance the availability of screening in schools and make it part of policy that students who transfer to a new school are screened. 4) State Child Fatality Review Team should request state funding for implementation of Chapter 284, Acts of 2014 An Act Related to Gun Violence (Section 12) for training of school personnel. Include funding for training students and require schools to set up protocols with community providers. Students have reported that they want access to a school-independent source of help to turn to. 5) Request that the MA chapter of the National Honor Society provide suicide prevention materials to all applicants and their parents.
Norfolk	<p>Methods of suicide by female teenagers should be tracked in order to gain information about whether methods are changing.</p>

Team	Recommendations: Suicide
Northwest	Increase hours of training and who is to be trained.
Worcester	DPH funding or other sources of funding for education and outreach to school staff and students
	Increased communication avenues between agencies involved including school personnel / school resource officers and funding related to intervention and post-vention.
Plymouth	We recommend that students who have lost a close family member to suicide within the year be closely monitored by their school system, including counselors and teachers. We recommend that be included in statewide policies for dealing with suicide in schools.
Team	Recommendations: Undetermined
Hampden	It is known that there is a significant backlog in the processing of rape kits statewide. The State Team should review current practices and consider the need for a concerted effort to process rape kits in a timely and expeditious manner.